

Acute urinary retention preceding skin manifestations of genital herpes by 8 days

Acute urinary retention is a well recognised, if rare, neurological complication of herpes simplex virus infection and occurs more frequently in women than man.¹ It is due to viral sacral myeloradiculitis.² Although the incidence is less than 1% in primary infection,³ it is now believed to be the commonest cause of acute urinary retention in young, sexually active men.¹ The condition is benign, transient and self limiting although the patient may need catheterisation for a few days or occasionally longer.⁴ Herpetic lesions are usually present at the time of urinary retention.¹ We describe a case of acute urinary retention preceding skin manifestations of genital herpes by 8 days.

A 25 year old male patient attended the genitourinary medicine (GUM) department complaining of dysuria for 2 days. Following standard investigations, a diagnosis of non-gonococcal urethritis was made and the patient was prescribed a course of oxytetracycline. The following day he was admitted via the A & E Department at St. Thomas' Hospital, complaining of inability to pass urine for 18 hours. He was not seen in the GUM Department at this time. Because of severe urethral discomfort and failure of attempts to insert a urethral catheter, suprapubic drainage was initiated and treatment with a course of ciprofloxacin started. Subsequently, the patient became pyrexial, developed inguinal lymphadenopathy and urethral discharge. He was referred back to our clinic where routine STD screening was repeated including urethral culture for herpes simplex virus (HSV). There were no skin manifestations of genital herpes at that time. The patient remained very uncomfortable and failed to pass urine after clamping the catheter. Two days later urethroscopy was planned but this was cancelled following the development of a small cluster of HSV like ulcers on the penis. The skin lesions appeared 8 days after the onset of urinary retention. A clinical diagnosis of genital herpes was made, further swabs for herpes simplex virus culture were taken and treatment with acyclovir 200 mg 5 times daily for 5 days was started with reassurance. All genital investigations were negative apart from urethral and penile swabs for herpes simplex viral culture. The patient

was discharged from the hospital with supra pubic catheter in situ which was removed 10 days later.

Primary genital herpes is commonly associated with systemic symptoms and prolonged duration of viral shedding and lesions. The infection presents with urethral discharge in 27% of men and dysuria in 44%.⁵ In our case, two factors delayed the immediate diagnosis of herpes simplex virus infection as the cause of urinary retention (although urethral swabs for HSV culture were taken). Firstly, initial findings were suggestive of non-gonococcal urethritis. Secondly, there were no skin lesions at the time of retention. These developed 8 days later. Urologists should be aware that urethral swabs for herpes simplex virus culture are indicated in cases of acute retention in young men. Early identification of virus spares the patient further urological investigations which are not only inappropriate but are likely to be very uncomfortable in this condition. We think that the presented case can also be instructive for genitourinary physicians who should bear in mind that skin manifestations of genital herpes do not have to be present at the time of urinary retention. Herpes simplex virus infection should be considered in cases of non-gonococcal urethritis with particularly severe dysuria. Urethral swabs for herpes virus culture would be most appropriate in such cases.

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